	•				•	HEALT	14 FEF 18511 MIN	ALTH FORM	: 10/12/2007 APPROVED	
	T OF DEFICIENCIES OF CORRECTION	ier/Clia Limber:	ADMINISTRATION COMPLETED  A BUILDING 2887 OCT 23 A 8: 37 10/09/2007							
NAME OF P	ROVIDER (IR SUPPLIER	09G182 -	3312 4TH	STREET, S	STATE, ZIP CO E 0032	DE .	,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICE INC. Y MUST BE PRECED ID B SC IDENTIFYING IN ORM	IPS Y FULL	ID PREFIX TAG	· PR(		E ACTION S		(XS) COMPLETE DATE	
1 000	INITIAL COMMEN	TS -	<del>- 1</del>	1 000				,		
	AM the State Agen concerning the can as described below		il ite clients							
		il Retardation Profes onthly reports at of ed July 2007;					-			
,	dated May 29, 200	nysician 's progress 7 indicated " por r or ork-up consider p	ral intake	-,,	-	,				
,	3. A review of Cities weight has been st pounds since Marc	nt#2] weight for real able, and gaine con th 2007;	realed that ie to two	-	. , -	-	\$ 			
	were reviewed reve	four clients who: e re ealed that regul; r co ded during the n onl niber 2007; and	ommunity	, .		•				
	implemented. For a evidence that the coand water to him be implemented; there #1 physical therapi Client #1 to lie in a ja day, three days a #1 was not wearing recommended by it had not been using recommended by it.	e was no eviden a ti st.'s recommen lati prone position is r te week was impleme g his biker's glaves his psychologist; and this communication his speech there sist n device was report	ito beverage  Itat client ion for in minutes ented Client uas D'Client #3 Indevice, as							
	The findings of the	investigation were i	based on		1	٠,				

Tealth Regulation Administration

"Now "Brown Brown Aboratory Director's OR PROVIDER'S UPPLIER REP (ESENTATIVES SIGNATURE)

DRS

10/18/07

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PRINTED; 10/12/2007 FORM APPROVED

(X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES (XZ) MULTIPLE CONSTRUCTION (XI) PROVIDER/SI PPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING B. WING 10/09/2007 09G192 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3312 4TH STREET, SE WASHINGTON, DC 20032 IDI PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEPIC MOIES COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECED D BYFULL REGULATORY OR LSC IDENTIFYING IN ORMATION) PREFIX TAG DATE TAG DEFICIENCY LOOD 1000 Continued From page 1 observations at the group home ar 1 one day program, interviews with greate her te and day program direct care staff, nursing and administrative staff, and review of Illentiand administrative records; including in adeat reports. 1500 3523.1 RESIDENT'S RIGHTS 1.500 Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. .aw 2-137, this 3523.1 Resident's Rights chapter, and other applicable District and federal laws. 10/30/07 See Federal Deficiency Report This Statute is not met as evidenced by: Citation W120 Based on observation, interview and record review, the GHMRP failed to ensul a the protections of each clients rights. The finding includes: (See Federal Deficiency Report Ci ation W120)

P5LE11

DEPARTMENT OF HEALTH AND HUMAN >ERVICES

PRINTED: 10/12/2007

FORM APPROVED

CENTER	RS FOR MEDICARE	ERVICES	OMB NO. 0938-0391							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SI AND PLAN OF CORRECTION (DENTIFICATION)			R PPLIBR/CLIA (CC) MULTI N NLIMBER A. BUILDING			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		09	1192	B. WI	NĠ		10/0	5 9/2007		
NAME OF P	ROVIDER OR SUPPLIER		1		3≾	EET ADDRESS, CITY, STATE, ZIP.CODE 312 4TH STREET, SE VASHINGTON, DC 20032	ZIP.CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN	ED BY FULL	ID PRES TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO OROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE		
. W 000	INITIAL COMMEN	TS		W	000	, ,	_			
	On September 26, AM the State Agen concerning the car as described below	cy received an i	mail		-	· · · · · · · · · · · · · · · · · · ·				
	Qualified Mental (QMRP) current mental 19, 2007 were date.	onthly reports a				·		. ,		
•	2. Primary Care Printer May 29, 200 with negative GI we PEG; "	7 indicated " po	r oral intake	-	-			-		
	A review of [Clie     weight has been st     pounds since Marc	able, and gaine	revisaled that	.	·					
•	4, Only one of the twere reviewed reviousings were provided August and Septer	ealed that regulation during the n	r community contins of	· ,			**			
	5. Clinical therapy implemented. For a evidence that the cand water to him b implemented; there	example, there in the street was provided the street was provided the street was no evident the street was not evident the street was provided the street was not evident the street was not evid	ras no ad beverage as as trat client	,						
	#1 physical therapi Client #1to lie in a a day, three days a #1 was not wearing recommended by I	prome position fi week was impl g his bliker's gk nis psychologist	rtet minutes mented Client ves, as and Client #3		į					
- •	had not been using recommended by h .communication de working" for the pa	nis speech them vice was reporte	pist / Client #34s	,				,		
ABORATOR	TORECTORS OR FROM	DERISUPPLIER REF	TESENTATIVES SIGN	ATURE		TITLE Des		CALLETO T		

Any deficiency statement ending with an asterisk (\*) den tes adeficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the path ats. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of corn clions provided.) For altering homes, the above findings and plans of correction are disclosable 14 days following the date those documents are made available to the facility. If deficiencies are often, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID! ERVICES

PRINTED; 10/12/2007 FORM APPROVED OMB NO. 0938-0391

CON TATE SHEVEY

AND PLAN	OF CORRECTION	IDENTIFICATI	N NUMBER:	A BU		6		.	COMPL	TED	
	•	09	:192	B. WI	NG <u>.</u>					C 9/2007	•
NAME OF P	PROVIDER OR SUPPLIER				3	REET ADDRESS, CIT 312 4TH STREET, VASHINGTON, D	SE .	DDE		-	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR U		DBY FULL	ID PREP TAG		(EACH COR	R'S PLAN OF CO RECTIVE ACTION RENCED TO THE DEFICIENCY)	SHOUL	DBE	COMPLE DAT	
W 000	Continued From par An investigation wan 2007 to verify comp standards of practic requirements in act protection.	s conducted on liance with the e and IOF-MR	asi¢ egul <del>at</del> ory	W	000			•			
W 120	The findings of the incomment observations at the program, interviews program direct care administrative staff, administrative record 483,410(d)(3) SERNOUTSIDE SOURCE	group home an with group hor staff, nursing a and review of a dis, including in /ICES PROVIC	i one day ne and day nd lient and ident reports.	W	: 120			· ·			
	The facility soust as meet the needs of e		selvices	İ	, ,				. •		
	This STANDARD is Based on interview failed to ensure that needs of one of four #1).	and record revi outside servici	w, the facility s met the				,				•
	The findings include						,	,	•	, i	
	On October 9, 2007 manager was intented that the clicas prescribed by the physician had not be noted that the fair prescibed interventationary as evidenced	viewed at 12:06 ent's behavior i e client's primar een implement iture to impleme on may have re	PM and tervientions care d. It should nt the		,						
	Client #1 has a b was prescibed "han worn for 1 hour duri	d mitts or blker	s glaves to be					· .		,	

	TMENT OF HEALTH		1 .				FORM	10/12/2007 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERIS IDENTIFICATI	PPLER/CLIA	(CC2) MU		CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
•	•	Œ9	<b>≥192</b>	B. WING		· · · · · · · · · · · · · · · · · · ·	ſ	C 9/2007_
NAME OF P	ROMDER OR SUPPLIER		.,			Address, City, State, ZIP Code		
LD I	,			, , ]		HINGTON, DC 20032	-	
(X4) ID PREFIX TAG		TEMENT OF DEPIC MUST BE PRECEL SCIDENTIFYING IN	ED BY FULL	PREFIX TAG		PRÔVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D BE	(XS) COMPLETION DATE
W 120	Continued From pa	ge 2		W 12	20	W120	<del>,</del>	
	injurious behaviors					This Standard will be me	t as	
	program's case ma					evidenced by:	•	
	had a pair of white validation. The car					•	-	
,	client did not wear							
	program did not ha	ve a physician':	order.		1.	QMRP will consult with the be-	havior	
.	Review of Client #1			1	ŀ	specialist at the residential and	day	10.30.07
٠	physician's order at					program sites as needed further		
,	prescribed "hand m worn for 1 hour duri					implementation of client #1's b	ehavior	ongoing
	injurious behaviors			'		support plan.		
	be noted that the pl	rysician's order	reversied that		1	QMRP will follow-up од a mor	athly	
,	the start date for the			•		basis to ensure receipt of behav		
	According to the da			, ,		documentation. QMRP will co	ntinue to	,
	client had previous exhibited sib behave			! ;		complete routine visits to the da		, ,
	CYLINICA SID BOWA	Mad mind and	, agy,	 ¦		program and address issues and		
	2. Review of the cl	ient's day prog	em habilitation	ļ .		concerns as they arise.	i.	ľ
,	record on October	9, 2007 reveale	l a Behavior	<b>-</b>		QMRP will coordinate addition	al training	· ·
	Support Plan (BSP)			٠,		as needed with day program sta		
	The plan document							,
	include sib (hand -b hand-biling behavio			,		•		·
,	wounds to the clien				2.	Client #1's behavior program de	oes include	
<i>'</i>	the residential provi	ider had implen	ented the use			proactive strategies to redirect of		
.	of a hand-mitt to pro	event injury. F	urther review			and to stop biting his hands. If		.'
,	of the plan revealed			'	,	biting continues and/or redirection		,
	incorporate the use					unsuccessful, the gloves should on his hands. QMRP will follow		
.	as part of an intervehand-biting behavior					indicated to ensure that the day		
	when the client exh			,		incorporates the use of gloves a		
	the day program sta					an intervention strategy to ad	-	-
	client) to stop in a c	alm way. If he	loes not stop			hand-biting.		1
	we explore why he	won't stop. For	example, if he					,
	is hungry, then we a	address his nec	is to eat.	1				

3. Behavior data was requested from the day program for the months of August and September 2007. The case manager informed the surveyor

3. Reference response to W120 #1 and #2.

4. Reference response to W120 #1 and #2.

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PRINTED: 10/12/2007 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN ! ERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID S ERVICES (X3) DATE SURVEY STATEMENT OF DETICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SU PLIER/CLIA OCEN MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATIO ( NUMBER: A BUILDING B. WING 10/09/2007 090 192 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3312 4TH STREET, SE 101 WASHINGTON, DC 20032 (75). COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICE NOTES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECED DETIFILL REGULATORY OR USC EDENTIFYING INF DRIMATION) PREFIX TAG TAG DEFICIENCY W-120 W 120 Continued From page 3 that he would check to see if the di ta Was available and if so, he would fax it to the state agency. [Tifne behavior data for St sterliber was received post survey and reviewed zero incidents of hand-biting.] He further noted that the behavior data might be with the Belravior Specialist who was not at the day program facility on aidaily basis.

4. Interview with the facility's hous I manager and review of records on October 9, 20 17 at 6:34 PMI revealed that the day program informed the facility (via "Intra-Agency Commun cation" form) on October 4, 2007 at 2:20 PM the "consumer exhibited his behavior" The form it vealed that the client bit himself right hand which I ad an old wound. Observation of the client's hand by the house manager on October 4, 200 ' revealed that the hand was red. Interview with it e day program staff revealed that the glove was n it being used during the incident.

W 124 483,420(a)(2) PROTECTION OF ( LIENTS RIGHTS

> The facility must ensure the rights of all clients. Therefore the facility must inform a chaclient. parent (if the client is a minor), or I galiguardian, of the client's medical condition, dr veldpmental and behavioral status, attendant risks of treatment, and of the right to refus : treatment.

This STANDARD is not met as evidenced by: Based on observation, interview at directord verification, the facility failed to do: ument actions taken to ensure the right of each c ientland/or legal guardian to be informed of the attendant risks of treatment and the right to I stude

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PRINTED: 10/12/2007 DEPARTMENT OF HEALTH AND HUMAN! ERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAIDS ERVICES (X3) DATE SURVEY OKI) PROVIDERSU PLIERICLIA IDENTIFICATIC I NUMBER (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A: BUILDING B: WING 10/09/2007 896 192 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3312 4TH STREET, SE IDI WASHINGTON DC 20032 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICI NCIES (EACH DEFICIENCY MUST BE PRESED) D BY FULL (XS) COMPLETION (X4) ID PREPIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INF TRANSTIONS TAG TAG DEFICIENCY W 124 W 124 Continued From page 4 treatment for one of the four client in the sample. (Client#1) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) via telephone revealed that Client#I had been approved for a juardian in W 124 April 2007. Further interview with 1 is QIMRP This Standard will be met as evidenced by: revealed that he would fax a document that 10.30.07 provide evidence of guardianship. QMRP will fully explain to client #1 and his ongoire mother the use of interventions to include risks/ Interview with the House Manager evebled that benefits of treatment, and the right to refuse Client #1 did not have the capacity o give treatment. OMRP will obtain written informed informed consent for the use of his medications, consent from client #1 and his mother. Information habilitation services, and finances. The interview will be filed in client #1's book for review was verified by the client's psychological assessment, dated July 5, 2007. A aconding to the assessment, Client #1 "does not a ridence the capacity to make independent deci tions on his behalf regarding his habilitation pla ming. treatment, placement, financial and medical matters." Further interview with the QNRP on September 27, 2007, at 4:01 PM, r -vealed that the client had family involvement (r lother) but did not have a legal quardian. Interview with the QMRP and revie v offClient #1's records failed to provide evidence hat informed consent was obtained for the use of the client's hand mitts. At the time of the surv v. the facility

W 159

to him and his mother.

483,430(a) QUALIFIED MENTAL

RETARDÁTION PROFESSIONAL

failed to provide evidence that Clie it #1's treatment needs, including the ben rifts

associated with the use of interven longand the fight to refuse treatment, had been fully explained

W 159

DEPART	MENT OF HEALTH	I AND HUMAN S	ERVICES RVICES	;			PRINTED: FORM OMB NO.	10/12/2007 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID S  STATEMENT OF DEFICIENCIES UND PLAN OF CORRECTION  (X1) PROVIDER/SUI IDENTIFICATIO		PLIER/C! IA	(X2) MI IA. BUIL		LE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY YED	
•••		09€	192	B. WIN			10/09/2007	
NAME OF PE	ROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·		33	ET ADDRESS, CITY, STATE, ZIP CODE 12 4TH STREET, SE ASHINGTON, DC 20032	· .	
(X4) ID PREFIX TAG	(EACH) DEFICIENC!	TEMENT OF DEFICE Y MUST BE PRECEDE SC IMENTIFYING INF	) BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AFP DEPICIENCY)		COMPLETION DATE
W 159	Continued From pa Each client's active integrated, coordin qualified mental re-	treatment prograted and monitor	ed tay a	<b>W</b> 1	159			-
	This STANDARD Based on interview Qualified Mental R (QMRP), falled to o treatment program established, Integram monitored for one sample. (Client #1	is and record reviet and record reviet ensure that client to include intervated, coordinates of four clients inc	ew the sional s active antions were and	•		W159 This Standard will be met as evid	enced by:	10:31 07
	The finding included the QMRP failed the treatment orders for 1 ho self-injurious behalf incoparated in his Plan (BSP). [See	to ensure that Cl or hand mitts or l our during exhibit wior(sib) to preve day program Bel	lkeds gloves onsof nt injury was	. 1		Reference response to W120. QMI and discuss client #1's behavior support specialist's. Q follow-up to ensure that client #1's support plan is integrated, coordina monitored on an ongoing basis. QN follow-up to ensure that physician's consistent with behavior support in both the day program and residentis	oport plan with the point plan will behavior ted and MRP will also to orders rematerventions at	th d
		•					· .	
				,	, .			
CODM CMS_2	S67/92-99) Previous Versio	ns Obsoleta	Event ID: P5LE11	ı ——	Fa	city 1D: 096192	de noticuation sh	eet Page 6 of 6